

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Friday, April 13, 2001
9:02 a.m.

COMMISSIONERS PRESENT:

GAIL R. WILENSKY, Ph.D., Chair
JOSEPH P. NEWHOUSE, Ph.D., Vice Chair
BEA BRAUN, M.D.
AUTRY O.V. DeBUSK
GLENN M. HACKBARTH
FLOYD D. LOOP, M.D.
ALAN R. NELSON, M.D.
JANET G. NEWPORT
CAROL RAPHAEL
ROBERT D. REISCHAUER, Ph.D.
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA ITEM:

Assessing the implications of the outpatient PPS for quality and access (Henry Miller, Ph.D., president, CHPS Consulting, Dana Karr, managing associate, CHPS Consulting)

P R O C E E D I N G S

DR. WILENSKY: Good morning. Chantal, do you want to introduce our guests?

DR. WORZALA: Good morning. Our first session today is a presentation of findings from an external research project on the potential impact of the outpatient PPS on access to quality care.

You may recall that last June we recommended that the Secretary monitor implementation of the outpatient PPS to ensure continued access to quality care. As a follow-on to that recommendation we contracted with the Center for Health Policy Studies or CHPS to take a preliminary look at the issue. Our goals in letting this contract were to identify potential problems in both the short and the long-term and to consider how quality and access could best be monitored in this particular setting.

With us today to present the results of their work are Henry Miller, President of CHPS, and Dana Karr, Senior Director and Project Manager. They'll be presenting the full scope of their findings, but also highlighting the findings pertinent to rural hospitals.

1 Dr. Miller has considerable experience with the design and
2 implementation of outpatient prospective payment systems for
3 private payers, state agencies, as well as the Medicare program
4 itself. Both Dr. Miller and Ms. Karr have worked extensively
5 with hospitals in preparing for and implementing the Medicare
6 outpatient PPS.

7 So with that, I'll turn it over to them.

8 DR. MILLER: Thank you. I just quickly want to introduce
9 the study and tell you that the things I want to talk about this
10 morning are findings, the specific findings that relate to rural
11 hospitals, and then the issues relating to the ongoing monitoring
12 of access to quality care for hospital outpatient services.

13 Certainly, as Chantal has just indicated what the impetus
14 for the study was, this is a study that was referred in the
15 Balanced Budget Act to MedPAC and certainly has been an issue of
16 some concern, as to whether or not this new payment system will
17 affect access to quality care for Medicare beneficiaries.

18 I identified, as did Chantal, what the goals of the study
19 were, so it isn't really critical to repeat those, other than the
20 focus was to get information on the perceptions of the effect of
21 the OPPI on access to quality care. The study had to focus on
22 perceptions because the implementation of the OPPI is new, only
23 since August 1st, and it is difficult to tell what the results or

1 what the impact is going to be.

2 Our approach included a literature review and then the bulk
3 of the approach, the bulk of the investigation, was based on
4 interviews with key informants. We interviewed about 80 people.
5 The 80 people, about 40 percent of those people, about 32 or 33
6 people were hospital administrators, representing urban,
7 suburban, rural hospitals, and academic medical centers. But we
8 also spoke with representatives of trade associations,
9 representatives of accrediting bodies, consultants and
10 researchers, as well as payers and government people, people from
11 both HCFA and AHRQ.

12 I think the summary of the findings is pretty
13 straightforward. Number one, it's too soon to tell whether or
14 not there's going to be an access to quality care effect that the
15 OPPS will have. There's reasons why it's too soon to tell. One
16 reason that's most important is that the system, as it was
17 eventually implemented through revised regulations, has a fairly
18 sufficient array of transitional payments, hold harmless clauses,
19 and grandfather clauses that will limit the impact in the short
20 term.

21 In this short term period, the impacts that have been
22 discussed, that were discussed with us as being most important,
23 were the ones that you would suspect, concerns about changes in

1 billing practices, concerns about coding, and concerns about
2 compliance where the hospital have had to make significant
3 changes, specifically in their coding, in order to have their
4 claims properly classified and paid under the APC system, and
5 their concerns about compliance pretty much relate to coding.

6 Their concerns about billing also relate to the newness of
7 the system and the difficulties that they encounter in trying to
8 determine how bills should be properly presented and what kinds
9 of problems can occur, primarily because this is a new system and
10 the intermediaries are not as up to speed on it as they will be
11 in a period of time. So the concerns about billing pretty much
12 related to that.

13 MR. DeBUSK: Let me make a comment here. I'm out there on
14 the firing line every day, seeing these problems with billing
15 coding and compliance. You talk about a major area of problem --
16 well, you can identify the problem. It's trying to solve the
17 problem. But education is the problem.

18 HCFA nor the intermediary, neither one, does a very good job
19 of informing the hospital, the billing department, about the
20 codes, how to go about it. It's lagging behind tremendously. So
21 you've got your hospital caught in a transitional period. And
22 when the costs is -- got to be tremendous now. Of course,
23 ultimately how that affects access and quality -- well, I'll let

1 you go on from there.

2 DR. MILLER: Just as a response, the comments you're making
3 are in fact the same comments we heard in our interviews, that it
4 was very difficult to get appropriate information from fiscal
5 intermediaries and from HCFA. And very frequently, people were
6 frustrated by not knowing who to ask.

7 MR. DeBUSK: I think one of the problems here is we don't
8 address in the beginning here of the process, the intermediary
9 and, of course you talk to the intermediary and they say well, we
10 don't have the funds to train. I think there's some truth to
11 this.

12 I think on the front end we fail to provide enough revenue
13 so they can do this thing properly. So we halfway do it and then
14 we get halfway results, and then we get full measure costs that
15 ultimately is a mistake on our part on our approach.

16 DR. MILLER: As this slide indicates on quality and access,
17 aside from these other effects that we were just talking about,
18 there hasn't been that much consideration of them so far. But
19 there have been some concerns and some speculation that was
20 offered in our study.

21 There are concerns relating to the payment system's design
22 itself. Some of those concerns are not necessarily obvious. The
23 payment system design, for example, includes an inpatient list

1 where Medicare will only pay for certain services if they're
2 provided on an inpatient basis.

3 While that is seen perhaps by many as a positive quality
4 effect, it's also seen by some hospitals and others as having a
5 negative effect because the hospitals have become used to
6 providing the services on an outpatient basis, they've developed
7 protocols for the provision of those services on an outpatient
8 basis, and many believe that they are most appropriately provided
9 in that way. So that inpatient list has turned out to be
10 somewhat of a two-edged sword.

11 The same thing can be said about the copayment requirements.
12 Whereas the copayment requirements are quite beneficial for
13 people who are using hospitals where charges were quite high, the
14 copayment requirements are gradually being reduced for those
15 people. But on the other hand, and this is something that
16 specifically affects rural hospitals, the copayment requirements
17 actually result in higher copayments for rural hospitals where
18 the charges have been fairly low in the past. And there are some
19 concerns about access in those rural hospitals because they are
20 concerned that the Medicare beneficiaries are not going to be
21 able to make that copayment payment if, in fact, they have to do
22 it themselves and don't have a supplemental policy.

23 DR. ROWE: Dr. Miller, do you think the study was done too

1 soon? I mean, if it's too soon to tell, maybe we shouldn't have
2 done it later, we should have done it later.

3 DR. MILLER: One aspect of the study, the part that we're
4 talking about now, it certainly is very early. The other aspect
5 of the study though, for us, was the identification of methods
6 that can be used to monitor change in access to quality services
7 over time.

8 DR. ROWE: Accepting the view that an investigator never
9 feels that it's not time to do a study, but holding you
10 completely harmless -- you know, in fact, if you were going to do
11 this again, and guaranteeing you would do it, and all the rest of
12 it, would we have been more thoughtful if we had planned together
13 with you and probably done this somewhat later? That's all.

14 DR. MILLER: I'm sure that there would be more definitive
15 results later, but the question would be how much later? In
16 fact, it would not be something -- you couldn't say okay, in
17 August of 2001 the system will have been in place for a year, is
18 that the right time to start studying the impact? In fact, I
19 think these impacts are going to be very gradual and picking the
20 time would be difficult. But without question, as time goes on,
21 the results will be much more easy to identify.

22 In terms of some of the other possible concerns, a number of
23 hospitals and others reported concerns about the shifting of

1 services from one setting to another, from the hospital
2 outpatient department to the physician's office. Also concerns
3 about the consolidation of services. For those services that
4 were not paid at a sufficient level in the APC system, the
5 concern was that some hospitals and hospital systems would
6 consolidate the availability of those services within their
7 systems or within an area which, of course, would diminish access
8 as it currently exists.

9 There was some concern among rural hospitals and in a moment
10 I've got a slide that specifically relates to rural hospitals.
11 But among rural hospitals the concern was that there would be
12 specific services that the rural hospitals could not continue to
13 afford to provide. And the two areas of service that came up
14 most frequently were emergency services and radiology services.
15 By no means was that a consistent reply but there certainly were
16 some hospitals that were indicating that that was an issue.

17 As we've said, I think the biggest concern is that there's a
18 great many unknowns remaining because the system is so new, and
19 so there is just some fear of the unknown that we were able to
20 identify.

21 There certainly are some positive impacts, in terms of
22 quality and access. The inpatient list, while it is a problem,
23 is also certainly a positive impact. Copayment improvements are

1 a positive impact for the majority of hospitals, it's just that
2 they affect some negatively.

3 Certainly, there is a dramatic improvement in diagnosis and
4 procedure coding among the hospitals, because that's required for
5 payment. And that will allow hospitals to both improve their own
6 utilization management systems on outpatient services, as well as
7 others being able to understand outpatient services a great deal
8 better.

9 MR. HACKBARTH: Can I ask a question about the inpatient
10 list? What I hear you saying is that there are services that
11 previously Medicare would pay for on an outpatient basis, but now
12 they're paid for only on an inpatient basis?

13 DR. MILLER: That's correct.

14 MR. HACKBARTH: Could you give some examples of those
15 services?

16 DR. MILLER: Specific examples? I don't think I can. I'd
17 have to look them up.

18 MS. KARR: I think that's an overarching theme. A lot of
19 the interviewees spoke in great generalities and said this is an
20 issue, but very few specifics about these particular services or
21 this particular procedure, in particular, is going to be
22 affected.

23 DR. MILLER: I would say part of the issue is that the OPPIs

1 does not include payment for observation. As a result, there is
2 certainly an understanding that some services require
3 observation. Those are the services that are more likely to be
4 included in the inpatient list. The inpatient list is not that
5 long, but nevertheless, there are some services that were
6 previously paid for on an outpatient basis.

7 MS. RAPHAEL: But you also said that was a positive. Could
8 you explain?

9 DR. MILLER: Yes. It's positive in the sense that if, in
10 fact, the judgment is correct that those are services where the
11 patient would be better off on the inpatient setting, then
12 certainly there would be more continuity of care, longer care
13 available to the patient. So it could certainly be seen as
14 positive. And I think anybody who was involved in the system
15 prior to its implementation would have assumed that that was a
16 positive impact. It's just that we have created protocols,
17 hospitals have created protocols and methods of care that have
18 left those services -- at least in the minds of the people that
19 we spoke to. They feel as though those services continue to be
20 best provided on an outpatient basis.

21 DR. WILENSKY: It's similar to the move to not pay for some
22 services any longer in the physician's office that were judged to
23 be more appropriately provided in an outpatient setting attached

1 to the hospital, but with the hospital services available. So we
2 obviously can, at some point, assess whether there is some
3 consensus judgment about the wisdom of those changes. But there
4 were some attempts to limit payment from what had been lower
5 intensity level places because of the feeling that they were not
6 provided with sufficient safety and backup services.

7 So it went both ways, from the outpatient to the inpatient,
8 and from the physician's office -- particularly in a number of
9 places where there was a move to not encourage things in the
10 physician's office, to get them back into the hospital clinic
11 setting, so that they would have the services of the hospital
12 available if there was a problem.

13 DR. MILLER: It's probably worth noting that this particular
14 concern was the most frequently mentioned by the interviewees.
15 So that across the board, even though there were several other
16 issues that arose, this one arose most frequently.

17 DR. NELSON: Dr. Miller, did you get the sense in your
18 interviews then that what was happening was a different protocol
19 or a different standard for handling Medicare patients, as
20 opposed to age 64 patients that emerged as a product of this?

21 DR. MILLER: Yes.

22 DR. NELSON: Does your gut tell you that Medicare patients
23 are receiving better care or worse care, if there's a different

1 standard?

2 DR. MILLER: I think that would be very hard to say. I
3 think the issue really is that it's based on the specific
4 patient. Certainly, if the service is provided on an outpatient
5 basis to somebody in the ages of 60 to 64, there's probably not
6 much difference for the patients aged 65 to 69. But that's not
7 to say that the patient over age 70 or over age 75 wouldn't best
8 receive that service on an inpatient basis.

9 I'm not trying to dodge the question. I think it is just
10 very difficult to answer.

11 MR. DeBUSK: These are APC codes that were established
12 codes. Now some of these have gone within the hospital and would
13 then come under the DRG coding system, right?

14 DR. MILLER: Yes, CPT codes that are not being classified
15 yet.

16 On the financial impacts, we've talked about them and I
17 don't think there's any great surprise there. One of the
18 concerns that we haven't spoke -- certainly there are significant
19 implementation costs that the hospitals have been concerned
20 about. They are concerned about decreased reimbursement. One
21 point that we heard consistently is that the rate of decrease in
22 outpatient payment that the hospitals are either anticipating or
23 experiencing at this point is considerably greater than HCFA's

1 projection.

2 The range that we were told was a reduction of from 3 to 25
3 percent. Of course, this is not by any means empirically
4 determined and is just based on the input of the specific people
5 that we spoke to. But that's considerably greater than HCFA's
6 determination. And that was pretty consistent, as well. It
7 wasn't as though that was the report of one or two hospitals.
8 That was pretty much across the interviewees.

9 MR. DeBUSK: Why?

10 DR. MILLER: One speculation as to why is because, it being
11 as early as it is in the implementation of the system, the
12 process of submitting and getting paid for claims is not as
13 straightforward as hopefully it will be in the future. So that
14 when the hospital looks at how much it's getting paid now, there
15 can be a great many claims that are going back and forth that are
16 pending or for which the full payment hasn't been received.

17 MR. HACKBARTH: So it's a cash flow --

18 DR. MILLER: That is one reason. I also think that the
19 hospitals that have done -- and among the people that we spoke
20 to, we spoke to consultants who had worked with hospitals to
21 calculate what the impact would be. And we ourselves have done a
22 good bit of that work for hospitals. And we've consistently, and
23 they've consistently measured a greater impact than the HCFA

1 projection. But in terms of why, it's very difficult to say.

2 MR. DeBUSK: I think the way the law has changed is that the
3 first diagnosis they pay 100 percent, and thereafter 50 percent.

4 DR. MILLER: There are several procedures for which the
5 first procedure the payment is at 100 percent. If an additional
6 procedure is performed during that same visit, not all of them
7 but certainly a significant number of procedures are subject to a
8 reduction of 50 percent, and any subsequent procedure at 50
9 percent.

10 But number one, that doesn't occur that frequently. Number
11 two, that has been the policy within the ASC payment system and
12 it occurs -- where more than one procedure is performed, it
13 occurs in a fairly limited number of cases. Certainly fewer than
14 10 percent of cases for ambulatory surgery. And for most other
15 procedures it occurs far less frequently.

16 So I don't know that that is that big an issue, but it is an
17 issue.

18 MR. HACKBARTH: Does the shortfall suggest that the hold
19 harmless system isn't working as anticipated?

20 DR. MILLER: Once again, that may be an issue of timing.
21 No, because the hold harmless component relates to specific
22 facilities. Certainly in the case of rural hospitals, they are
23 being held harmless. And some of the concerns that we are

1 hearing relate to what will happen when that transitional period
2 is eliminated and some of the concerns relate to the fact that
3 there's just a lag in payment, and it may very well just be a
4 cash flow issue. I think in those situations it is just a cash
5 flow issue.

6 DR. WILENSKY: Don't you think it's also maybe a question of
7 whether the perceptions are actually reflecting reality? I think
8 people have to be a little careful about accepting perceptions of
9 people very early in the system. It may well be that some of
10 these effects will turn out to be true, but we're not looking at
11 audited financial statements. We're looking at where people
12 think they're going to end up after they do a year in settlement
13 in a system that's just starting.

14 So I think to go back to Jack's point, probably if we were -
15 - you could imagine doing a pre-PPS baseline study and then doing
16 a study two or three years later, a significant reason for doing
17 the study is that the BBA directed us to do such a study. We can
18 think about whether it would be appropriate to redo some aspect
19 of all of this later when there's been a shake out, whatever
20 occurs in terms of getting billing procedures and you know where
21 you are.

22 But I think you have to be a little cautious on assuming
23 that perceptions early in the system of financial impact actually

1 reflect the financial impact.

2 DR. ROWE: I agree. My concern about the timing is only
3 partly a concern with respect to the validity of the data. The
4 other concern is how the findings will be used because people who
5 don't like this system are going to jump on these early findings
6 and run around town with them in the press and on the Hill and
7 everywhere else saying see, we told you, when in fact they may
8 not reflect the system at steady state.

9 DR. WILENSKY: And in fact probably won't.

10 DR. ROWE: So that's my concern, is that you're almost
11 better off without the data. I was accused yesterday of
12 operating in a data-free environment, so I just want to continue
13 to build my reputation with respect to this.

14 But you're almost better off without it, if it's not valid
15 or not steady state, given the environment that we're in.

16 DR. WILENSKY: Almost better off unless it's a
17 congressionally requested study. You can try to be as clear as
18 you can about this is perceptions and not financial.

19 DR. ROWE: It should probably say preliminary report or
20 something like that.

21 DR. MILLER: In fact, the study is titled the potential
22 impact and we're trying very hard to report that these are in
23 fact perceptions. And it is speculation at this point. There's

1 a little bit of information that's coming out of it this early.
2 But for the most part, this is the expectation rather than the
3 reality.

4 I just have a couple of more comments that I would like to
5 finish, and specifically as it relates to rural hospitals. Some
6 of these we've already talked about. One of the things that we
7 found was that, in addition to the rural hospitals being
8 protected in the short term, they are very concerned about what
9 will happen when the period of protection ends.

10 A second point is that there's a great deal of attention
11 being focused by a large number of rural hospitals, more than
12 ever before, on applying for and becoming critical access
13 hospitals, which will provide them with some freedom from some of
14 the concerns that they have.

15 The concerns about quality and access really relate to the
16 elimination of services and the services again that were reported
17 most frequently by rural hospitals were concerns about emergency
18 departments and radiology services that could not be continued by
19 the hospital because the payment levels weren't sufficient.

20 Now this clearly is a perception. We did not identify any
21 hospitals where these services had been discontinued or where
22 there was a firm plan to discontinue them, but these were issues
23 that were raised.

1 We identified the issue of high copayments. One other
2 thing about rural hospitals that is important is that, like the
3 DRG system, the APC system is an averaging system, which means
4 that when a hospital provides a service and submits a claim
5 sometimes the APC payment will be higher than the resources that
6 require to provide care to the patient. And sometimes it will be
7 lower.

8 The implication that we heard consistently was that rural
9 hospitals having much lower volumes were at far greater risk
10 because of this averaging process and the fact that they could
11 conceivably have far more cases that were paid at a lower level
12 and wouldn't have the opportunity to average them with those that
13 were paid at the higher level. So that was again a speculative
14 concern, but nevertheless a concern that the hospitals had.

15 Finally, a component of our work was to identify a method or
16 indicators to measure quality and access as they change under the
17 system, so that there is an empirical basis for determining
18 whether or not these changes are occurring.

19 This turns out to be a very difficult task and a challenging
20 task for MedPAC, as well as for us within the constraints of our
21 work. The reason it's challenging is because very little
22 attention has been paid so far to measuring and collecting data
23 on outpatient services. The primary data that's available is on

1 inpatient services and you can look at inpatient services at
2 great length thanks to the hospital discharge data systems that
3 exist across the country.

4 There are very few comparable outpatient systems. There are
5 some, but they are very few and they are based in specific
6 states. So that if you wanted to look at New York or Maryland,
7 for example, you can look at ambulatory surgery at length. But
8 you couldn't necessarily do that in very many other places.

9 The data sources that would ordinarily be available also
10 have a limitation in that they focus on a single provider. One
11 of the concerns here would be that services are being shifted
12 from outpatient departments to physician offices. There are very
13 few data systems that would allow you to pick that up because as
14 few data systems as there are in outpatient services, there are
15 even fewer on physician services. So it becomes very difficult
16 to do that.

17 One more point, there are some surveys that are available.
18 There is the Medicare beneficiary survey and there are other
19 surveys that look at services provided across the board. But the
20 problem with surveys is they don't allow you to examine the data
21 in detail because they're typically based on a national sample,
22 so you can't break it down by geography. And frequently, you
23 can't break it down by type of provider. So that if you wanted

1 to look at rural hospitals or you wanted to look at academic
2 medical centers those surveys would not be a very fruitful source
3 of information.

4 So all of this says that it's quite difficult to come up
5 with recommendations for monitoring, although our approach has
6 been to focus on two questions. The first question being what is
7 it that MedPAC would be most interested in monitoring? What
8 specific aspects of services are most important? And the second
9 is given that we can narrow it down to those specific indicators
10 that would be most important to look at, what are the sources of
11 information available to them? Or what source of information can
12 be created?

13 DR. NEWHOUSE: Help me with the following problem. It seems
14 to me it doesn't help to talk about access to outpatient hospital
15 services except in the context of substitute sites, such as
16 offices, rural health clinics, ASCs, inpatient services. So any
17 plan to monitor or study this downstream seems to me has to be
18 holistic.

19 DR. MILLER: I should have said that. It needs to focus on
20 the service and not necessarily the provider. It's more
21 important to note that the service is being provided in some
22 setting.

23 DR. NEWHOUSE: Exactly, and my druthers would be to say that

1 if for no other reason than to forestall a mandate to study
2 access to hospital outpatient services.

3 DR. MILLER: In fact that is the direction that we're
4 taking.

5 DR. WILENSKY: Any other questions?

6 DR. WAKEFIELD: Just a comment. I appreciated your comment I
7 think you were making about the difficulty in collecting data and
8 we heard from somebody in the audience at the end of yesterday's
9 session who spoke about the MCBS and its really problematic
10 undersampling, especially of rural Medicare beneficiaries. I
11 think that just -- for another discussion at another time --
12 speaks to the need to really try and get a handle on ways that
13 HCFA and others can more frequently oversample or use other
14 sampling techniques to try and cull out with a little bit more
15 accuracy a better reflection because it is such a difficult
16 sample to get at, given the variation across rural areas.

17 DR. NEWHOUSE: Mary, does it undersample rural nationally or
18 is the issue that because of the cluster sampling it's not
19 representative of a specific UIC code?

20 DR. WAKEFIELD: I thought the answer to that question
21 was both, but I'd have to defer to the person who was speaking to
22 it last night. You could ask her, I think she's here.

23 If I could just finish that question. To that question, I

1 was just wondering out of curiosity, on the hospitals, where you
2 list on page three the types of organizations that you sampled,
3 could you tell me just a little bit more about the 53 hospitals
4 who you included here? A little bit of a sense of what they look
5 like?

6 MS. KARR: Actually there were 25 hospitals.

7 DR. WAKEFIELD: So 53 contacted and 25 who participated. So
8 on those 25, a little bit more about what they looked like?

9 MS. KARR: They were geographically dispersed. They were
10 handpicked, though, as hospitals that had looked at APCs or had
11 some consideration before. Some of them were in inner-cities. I
12 can tell you their location in just a minute.

13 I think some of the inner-city hospitals were in Dallas and
14 New York City, Little Rock, Arkansas, geographically dispersed.
15 But again, it wasn't a national sample.

16 DR. WAKEFIELD: Some under 50 bed and over 50 bed rurals in
17 both categories?

18 MS. KARR: Yes. Actually, average bed size for the inner-
19 city hospitals was pretty large, 974. For rural hospitals, we
20 looked at eight rural hospitals in Ohio, Mississippi, California,
21 Vermont, Tennessee, Idaho, Pennsylvania, and Maine. The average
22 bed size there actually was fairly large for rural hospitals, was
23 144.

1 Suburban hospitals in New York, Illinois, California,
2 Arkansas and New Jersey, average bed size 457. Academic medical
3 centers in New York, Michigan and Missouri average bed size 658.

4 DR. ROWE: One of the questions that came up when we were
5 discussing these proposed changes over the last couple years had
6 to do with the different patient populations that are seen in
7 different sites for outpatient care. One of the concerns that we
8 had was that the hospital outpatient units might
9 disproportionately have a population that was say
10 disproportionately enriched with frail elders, people who weren't
11 really able to just go to a doctor's office but would be in a
12 hospital outpatient clinic, people with more comorbidities,
13 perhaps people with dementia, people who needed more supports to
14 get around, et cetera, and just needed more resources that would
15 be more available or might even be patient populations that were
16 less sought after by some providers and therefore wound up in the
17 clinic, if you will.

18 Certainly, in geriatric medicine there aren't many
19 geriatricians practicing in the community. Where there are
20 geriatricians, and there aren't that many of them, they're
21 usually associated with hospitals and outpatient clinics.

22 So one of the considerations, I think, from that would be
23 that as you go forward, or as you look at the data, if you can,

1 it's not just the patient population. But if you could stratify
2 in some way by advanced age or some measure of frailty or a
3 number of diagnoses or some diagnostic marker such as Alzheimer's
4 disease that might be the primary or secondary diagnosis, I think
5 that my concern with respect to access and quality would be with
6 respect to particularly that patient population.

7 So if you could look at that in some way, I think that might
8 be informative.

9 DR. WILENSKY: Other comments or questions?

10 DR. REISCHAUER: Just to follow up on what Joe was saying.
11 As you think about wanting to analyze the impact of this change
12 in policy, from an individual standpoint you're worried about the
13 quality and quantity of services that are used. But you also
14 care about where those are in a geographic sense as opposed to
15 just is it in an outpatient or a physician's office? Are people
16 having to travel another 50 miles to get these services?

17 And you also are interested in issues of institutional
18 survivability and the evolution of institutions over time. If
19 the outpatient departments begin to shrink, it might say
20 something about the ability to attract certain kinds of health
21 care professionals to certain rural environments. Or it might
22 say something about the long run viability of these institutions
23 which you won't pick up in the first five years, but 10 years

1 later you'll find that this change has in fact had a larger
2 impact on the structure of medical care providers across the
3 country.

4 DR. WILENSKY: Further comments?

5 Thank you.